TELEMEDICINE REFERRAL

Patient Name: _____ _____ DOB: _____

First Last mm/dd/yyyy

Athanasius Healthcare LLC. have either diagnosed and/or will be treating this person for their behavioral health condition. Due to changes in the Public Health Emergency (PHE) effective May 11, 2023, and the Ryan Haight Act, we kindly ask that you complete and sign this form to ensure uninterrupted care for our mutual patient. In doing so, please complete the following information and acknowledge the following:

1. Based on my most recent in-person exam on_____, I cleared this patient for treatment with controlled substances if needed. 2. The patient is referred to Athanasius Healthcare LLC. for behavioral health treatment.

If you feel there is any pertinent information to share with our prescribing providers, please include it with the submission of this form

PROVIDER NAME AND CREDENTIALS

Provider Name:_____ State _____

State License #:_____ DEA number:_____

Practice Name:_____ NPI:_____

Practice Address:_____

Practice Phone Number:_____ Practice Fax #: _____

Examination Date:_____ Date of Attestation:_____

Signature:_____

When completed, send this form to your patient. You can also share it with

athanasiushc@gmail.com

Athanasius Healthcare LLC

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